A HEALTHIER RHODE ISLAND BY 2010
A PLAN FOR ACTION

SAFE AND HEALTHY LIVES IN SAFE AND HEALTHY COMMUNITIES
RHODE ISLAND DEPARTMENT OF HEALTH

MAY 2004

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LETTER FROM THE DIRECTOR

The Healthy People initiative, begun in 1979 and reformulated each decade, provides an annual review of the progress of the health of Americans. The initiative aims to improve the quality of life and eliminate health disparities for all Americans.

Healthy People offers a simple but powerful idea: provide information and knowledge about how to improve health in a format that enables diverse groups to combine their efforts and work as a team. Healthy People has become the Nation's road map to good health because it organizes the best scientific knowledge in a format that is useful for decision-making and for action.

Healthy People 2010, the third set of decade-long goals, addresses trends of this decade, including a larger, more diverse, and aging population and a host of health risks such as emerging infectious diseases.

Like most states, Rhode Island has produced its own version of the Healthy People initiative. Healthy Rhode Islanders 2010, building on Healthy Rhode Islanders 2000, follows the lead of the Federal government by adopting ten leading health indicators and a subset of 27 objectives. With our partners, the Rhode Island Department of Health has established baselines and targets for these 27 objectives as well as information on nationally documented best practices addressing each objective. It is our intention that Rhode Island organizations and individuals use this information to develop and implement interventions to improve the quality of life and eliminate health disparities for all Rhode Islanders.

We hope this Plan for Action will provide a solid foundation for a Healthier Rhode Island by the year 2010. We look forward to working with all of our collaborators on the next phase of this essential public health planning process.

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ACKNOWLEDGMENTS

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INTRODUCTION

Healthy People 2010 is a nationwide health promotion and disease prevention agenda for improving the health of all people in the United States during the first decade of the 21st century. Healthy People 2010 builds on similar initiatives from the last two decades, the most recent being Healthy People 2000, which identified health improvement goals to be reached by the year 2000.

Healthy People 2010 represents ideas and expertise from a diverse group of individuals and organizations concerned about the Nation's health. These groups include:

• Over 350 National organizations;
• Over 250 State public health, mental health, substance abuse, and environmental agencies; and
• Members of the general public from every State, the District of Columbia, and Puerto Rico.

Goals and Objectives of Healthy People 2010

The Healthy People 2010 agenda has two overarching goals:

• Increase quality and years of healthy life; and
• Eliminate health disparities.

These two goals are supported by specific objectives in 28 focus areas. Each objective was developed with a target to be achieved by the year 2010. The Healthy People 2010

consortium adopted ten Leading Health Indicators (LHIs) as a way to measure progress towards the objectives. For each of the following LHIs, specific objectives derived from Healthy People 2010 will be used to track progress and to provide a snapshot of the nation's health:

• Physical Activity
• Overweight and Obesity
• Tobacco Use
• Substance Abuse
• Responsible Sexual Behavior
• Mental Health
• Injury and Violence
• Environmental Quality
• Immunization
• Access to Health Care

The development of strategies and action plans to address one or more of these indicators can profoundly increase the quality of life and the years of healthy life of people nationwide, and can help eliminate health disparities.

HEALTHY PEOPLE 2010 IN RHODE ISLAND

Rhode Island, like many other states, has adopted the Healthy People 2010 agenda using the ten Leading Health Indicators and corresponding objectives as a roadmap toward a healthier Rhode Island by 2010.

The Rhode Island Department of Health (HEALTH) embarked on the development of the Healthy Rhode Islanders 2010 (HRI 2010) plan by:

1. Conducting a progress review of Healthy Rhode Island 2000 efforts;

2. Adopting the ten Healthy People 2010 Leading Health Indicators and a subset of 27 objectives (see page 8 for a list of state-level objectives);

3. Identifying state-level data sources, establishing baselines, and setting targets for each of the 27 objectives;

4. Charting baseline data by race and ethnicity, gender, household income, education level, geographic location, age group, and disability status; and

5. Documenting evidence-based strategies and best practices addressing each Leading Health Indicator and objective.

A note on objectives: As part of the HRI 2010 agenda, HEALTH is tracking the state's progress on 27 objectives associated with the ten Leading Health Indicators. The national agenda is tracking a larger set of objectives. For more information on objectives on the national agenda, visit the Healthy People 2010 website at www.healthypeople.gov.

HEALTH developed a series of public reports addressing each of these topic areas. See Table 1 for a full list of HRI 2010 reports available from HEALTH.

TABLE 1. HRI 2010 REPORTS AVAILABLE FROM HEALTH

TITLE	**Healthy Rhode Islanders 2000 Progress Review**
CONTENT	Review of progress towards 27 state-level objectives for 2000
TITLE	**Healthy Rhode Islanders 2010: Baselines and Targets**
CONTENT	State-level data sources, baselines, and targets for each of the 27 objectives
TITLE	**Healthy Rhode Islanders 2010: Leading Health Indicators by Race and Ethnicity**
CONTENT	Baseline data for the state by Race and Ethnicity
TITLE	**Healthy Rhode Islanders 2010: A Baseline Report. Leading Health Indicators by Gender, Household Income, Education Level, Geographic Location, Age Group, and Disability Status**
CONTENT	Baseline data for the state by Gender, Household Income, Education Level, Geographic Location, Age Group, and Disability Status
TITLE	**Evidence-Based Strategies and Best Practices for Leading Health Indicators**
CONTENT	National Best Practices addressing each Leading Health Indicator

All HRI 2010 reports are available at:
http://www.health.ri.gov/chic/healthypeople/home.htm

ABOUT THIS PLAN

This Plan is intended for public health practitioners, worksites, schools, health care providers, legislators, educators, community groups, researchers, and other individuals and organizations working to improve the health of Rhode Island residents.

The Plan provides a snapshot of how Rhode Islanders measure up to HRI 2010's 27 objectives and an overview of evidence-based strategies and best practices to address each objective. Each section corresponds to one of the ten Leading Health Indicators (LHIs). Under each LHI, the Plan presents the following information:

The Issue: National data and background for each LHI. Information in this section was adapted from Healthy People 2010: Understanding and Improving Health. For detailed information about national objectives, baselines and targets, visit www.healthypeople.gov.

In Rhode Island: An overview of the issue in Rhode Island, including state-level baseline and target data for each objective. The data presented in this section are pulled from various data sources that track health data for Rhode Island.

Greatest Health Disparities: A summary of health disparities including race and ethnicity, gender, household income, education level, geographic location, age group and disability status. Information on health disparities is based on a detailed analysis of these factors, available in full reports entitled:

• Healthy Rhode Islanders 2010: Leading Health Indicators by Race and Ethnicity, and
• Healthy Rhode Islanders 2010: A Baseline Report. Leading Health Indicators by Gender, Household Income, Education Level, Geographic Location, Age Group, and Disability Status.*

Data sources used to determine state-level baselines and health disparities can be found in Appendix A of this report.

See Appendix B for a chart on "Health Disparities At-A-Glance."

Meeting the Challenge: An overview of national best practices and evidence-based strategies addressing each LHI. See Appendix C for a list of references used to compile this section. Each source applied varying levels of scrutiny in evaluating its recommendations.

Taken together with the other HRI 2010 reports referenced above, the Plan is intended to guide programming decisions, fundraising, advocacy, policy-making, and a range of other activities that impact the health of Rhode Islanders. The information made available through HRI 2010 efforts will equip our state to meet HRI 2010 goals.

* **Detailed information about HRI 2010's objectives, baselines, targets, disparities and best practices can be referenced in full reports at www.health.ri.gov/chic/healthypeople/home.htm.**

HEALTHY RHODE ISLANDERS 2010
LEADING HEALTH INDICATORS (LHIs) AND OBJECTIVES

LHI 1: Physical Activity

Objective 1-1: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day (National Objective 22-2).

Objective 1-2: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion (National Objective 22-7).

LHI 2: Overweight and Obesity

Objective 2-1: Reduce the proportion of adults who are obese (National Objective 19-2).

Objective 2-2: Reduce the proportion of children and adolescents who are overweight and obese (National Objective 19-3c).

Objective 2-3: Increase the proportion of persons aged 2 years and older who consume at least 5 daily servings of fruits and vegetables (National Objectives 19-5 and 19-6).

LHI 3: Tobacco Use

Objective 3-1: Reduce cigarette smoking by adults (National Objective 27-1a).

Objective 3-2: Reduce cigarette smoking by adolescents (National Objective 27-2b).

LHI 4: Substance Abuse

Objective 4-1: Increase the proportion of adolescents not using alcohol or illicit drugs during the past 30 days (National Objective 26-10a).

Objective 4-1a: Increase the proportion of adolescents who report no alcohol use in the past 30 days.

Objective 4-1b: Increase the proportion of adolescents who report no cocaine use in the past 30 days.

Objective 4-1c: Increase the proportion of adolescents who report no marijuana use in the past 30 days.

Objective 4-2: Reduce the proportion of adults using illicit drugs during the past 30 days (National Objective 26-10c).

Objective 4-3: Reduce binge drinking by adults in the past 30 days (National Objective 26-11c).

LHI 5: Responsible Sexual Behavior

Objective 5-1: Increase the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past 3 months, or used condoms at last sexual intercourse (National Objective 25-11).

Objective 5-2: Increase the proportion of unmarried sexually active persons who use condoms (National Objective 13-6).

Objective 5-2a: Increase the proportion of unmarried sexually active adult females who use condoms (National Objective 13-6a).

Objective 5-2b: Increase the proportion of unmarried sexually active adult males who use condoms (National Objective 13-6b).

LHI 6: Mental Health

Objective 6-1: Increase the proportion of adults with recognized depression who receive treatment (National Objective 18-9b).

Objective 6-2: Reduce the suicide rate (National Objective 18-1).

LHI 7: Injury and Violence

Objective 7-1: Reduce deaths caused by motor vehicle crashes (National Objective 15-15a).

Objective 7-2: Reduce homicides (National Objective 15-32).

LHI 8: Environmental Quality

Objective 8-1. Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone (National Objective 8-1a).

Objective 8-2: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke (National Objective 27-10).

Objective 8-3: Eliminate elevated blood lead levels in children (National Objective 8-11).

Objective 8-4: Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act (National Objective 8-5).

Objective 8-5: Increase the proportion of persons who live in homes tested for Radon concentrations (National Objective 8-18).

Objective 8-6: Reduce infections caused by key foodborne pathogens (National Objective 10-1).

Objective 8-6a: Reduce infections caused by key food-borne pathogens: Campylobacter species (National Objective 10-1a).

Objective 8-6b: Reduce infections caused by key foodborne pathogens: Salmonella species (National Objective 10-1b).

LHI 9: Immunization

Objective 9-1: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years (National Objective 14-24a).

Objective 9-2: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease (National Objective 14-29).

Objective 9-2a: Increase the proportion of adults aged 65 years and older who are vaccinated annually against influenza (National Objective 14-29a).

Objective 9-2b: Increase the proportion of adults aged 65 years and older who have ever been vaccinated against pneumococcal disease (National Objective 14-29b).

LHI 10: Access to Healthcare

Objective 10-1: Increase the proportion of persons with health insurance (National Objective 1-1).

Objective 10-2: Increase the proportion of persons who have a specific source of ongoing care (National Objective 1-4a).

Objective 10-3: Increase the proportion of pregnant women who receive early and adequate prenatal care (National Objective 16-6b).

1. PHYSICAL ACTIVITY

The Issue

Regular physical activity over the course of one's life is critical to maintaining good health, enhancing psychological well-being, and preventing premature death. Demonstrated benefits of physical activity include the reduced risk of diabetes and colon cancer, increased muscle and bone strength, improved agility, and assistance with weight control.

According to figures from the Centers for Disease Control and Prevention (CDC), in 1999 only 65% of adolescents nationwide engaged in the recommended amount of physical activity. Data from 1997 showed that only 32% of adults in the U.S. engaged in the recommended amount of physical activity.

In Rhode Island

Twenty-two percent (22%) of adults in Rhode Island engage in regular physical activity daily. Sixty-two percent (62%) of adolescents engage in physical activity that is vigorous enough to promote cardiorespiratory fitness according to general health guidelines. Healthy Rhode Island 2010 objectives seek to raise those figures to 30% and 85%, respectively.

PHYSICAL ACTIVITY IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

ADULTS OBJECTIVE: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day.

22%[1] 30%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

ADOLESCENTS OBJECTIVE: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.

62%[2] 85%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
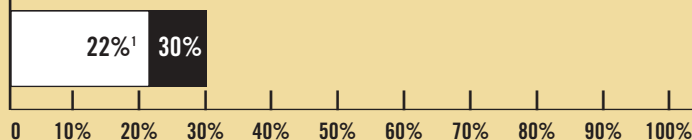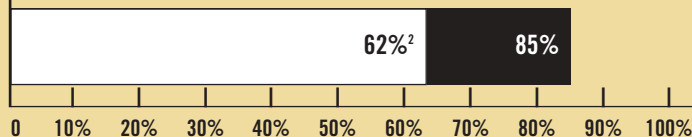
Data Sources: 1) 1998-2000 BRFSS; 2) 1997 YRBS

Greatest Health Disparities

Although most Rhode Islanders still need to increase their levels of physical activity to meet the state's overall 2010 objective, greatest health disparities exist among:

• Rhode Islanders over the age of 25,
• Black and Hispanic adults,
• Rhode Islanders with disabilities, and
• Rhode Islanders with lower levels of education and income.

Rhode Island adults aged 18-24 have met the 2010 target for getting regular exercise, as have those with annual household incomes of $75,000 or more.

Overall increases in the number of adolescents who participate in regular fitness activities will be necessary to meet the 2010 target. Greatest health disparities, however, exist among:

• Hispanic adolescents,
• Adolescent females, and
• Adolescents in the 12th grade.

Meeting the Physical Activity Challenge

1. *Implement individually based strategies* delivered in group settings or by mail, telephone, or directed media such as:
   • Developing networks to bring together people who are interested in increasing their levels of physical activity;
   • Teaching participants to monitor and change their personal behavior related to exercise and activity. Tailor programs to each individual's specific interests, preferences, and readiness for change; and
   • Placing point-of-decision prompts (signs) by elevators and escalators that encourage people to use nearby stairs for health benefits or weight loss.

2. *Implement multi-component community based strategies* including:
   • Support or self-help groups;
   • Physical activity counseling, risk factor screening and education;
   • Community health fairs and other community events;
   • Environmental or policy changes such as the creation of walking trails; and
   • Widespread public education and media campaigns.

3. *Implement school based strategies* that focus on increasing the intensity level of activity performed by students during physical education class time by:
   • Changing the curriculum to include more vigorous games and exercises (e.g., substitute soccer for softball);
   • Modifying the rules of the game so that students are more active (e.g., in softball, have the entire team run the bases together when the batter makes a base hit); and
   • Making physical education classes longer.

4. *Implement worksite strategies* that encourage employees to increase physical activity by:
   • Supporting company fitness challenges, lunchtime walking/running clubs or company sports teams;
   • Contracting with health plans that offer free or reduced-cost memberships to health clubs; and
   • Allowing flexible work schedules so employees can exercise.

2. OVERWEIGHT AND OBESITY

The Issue

Nationwide, the number of overweight children, adolescents, and adults has risen significantly over the past four decades. More than half of adults in the U.S. today are estimated to be overweight or obese. Overweight and obesity are major contributors to many preventable causes of death.

In addition to severe health complications, obese individuals also may suffer from social stigmatization, discrimination, and lower self-esteem.

Between 1988 and 1994, 23% of adults aged 20 years and older were considered obese. During the same years, 11% of children and adolescents aged 6 to 19 years were overweight or obese.

Healthy eating habits significantly impact overweight and obesity. Research data show that 28% of the country's population over the age of 2 consumes the daily requirement of fruit, while only 3% consumes the daily requirement of vegetables.

In Rhode Island

In Rhode Island, 17% of adults are considered obese, and 25% of the state's children and adolescents are either overweight or obese. State objectives seek to lower those figures to 14% and 10%, respectively. Approximately 27% of the state's adult population consumes a minimum of five daily servings of fruits and vegetables. State objectives seek to raise that figure to 50%.

OVERWEIGHT & OBESITY IN RHODE ISLAND

- ☐ BASELINE
- ■ TARGET 2010

ADULTS OBJECTIVE: Reduce the proportion of adults who are obese.

14% 17%[1]

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

ADOLESCENTS OBJECTIVE: Reduce the proportion of children and adolescents who are overweight and obese.

10% 25%[2]

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
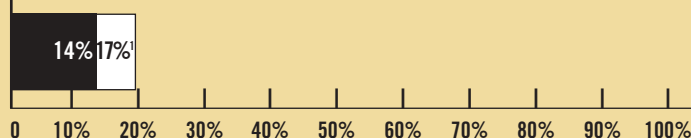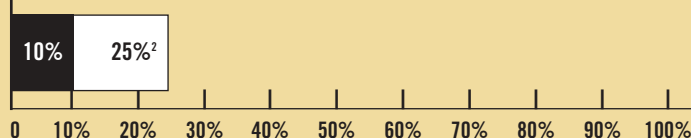
Data Sources: 1) 1998-2000 BRFSS; 2) 2001 RI HIS

Greatest Health Disparities

While many Rhode Island groups will benefit from reducing overweight and obesity, greatest health disparities exist among:

- Adults aged 45 to 64,
- Rhode Islanders with disabilities,
- Rhode Islanders with less than a high school education,

OVERWEIGHT & OBESITY IN RHODE ISLAND

☐ **BASELINE**
■ **TARGET 2010**

FRUIT AND VEGETABLE OBJECTIVE: Increase the proportion of persons* aged 2 years and older who consume at least five daily servings of fruits and vegetables.

27%[1]   50%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

Data Sources: 1) 1998-2000 BRFSS

*Data available for adults aged 18 and over.

• Children and adolescents with household incomes below the federal poverty level,
• Black adults and adolescents, and
• Hispanic adolescents.

Additionally, the obesity rate among Hispanic adults is higher than White adults, and higher among adult males than adult females.

Rhode Islanders with a college degree or more and adults who are 20 to 24 years old have met the 2010 target for reducing obesity. Asian/Pacific Island adults have surpassed the 2010 target.

Fruit and Vegetable Consumption
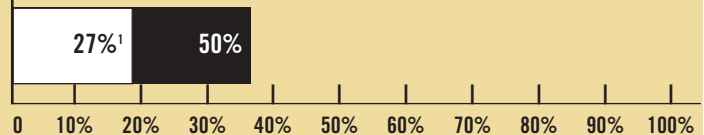While many Rhode Islanders will benefit from increasing fruit and vegetable consumption, greatest health disparities exist among:

• Adult males,
• Black adults, and
• Rhode Islanders with less than a high school education.

Additionally, those with lower incomes are farther from the target than those with annual household incomes of $75,000+. Those who live in urban areas are farther from the target than non-urban dwellers. And older adults (65+ years of age) are farther from the target than younger adults.

Meeting the Overweight and Obesity Challenge

1. *Individually based strategies*
   • Increase physical activity (see evidence-based strategies under "Physical Activity").
   • Promote breastfeeding by developing social support resources for breastfeeding women and training health care professionals to promote breastfeeding among their patients.
   • Increase fruit and vegetable consumption.

2. *School based strategies*
   • Educate policy makers, health advocates, and the general public about the importance of requiring daily physical education classes and state-of-the-art nutrition education in the core curriculum in kindergarten through 12th grade.
   • Provide support, training, and technical assistance to help schools and community organizations create programs such as:
      • Food service programs that are consistent with USDA school meal program regulations and physical education programs that are consistent with the National Standards for Physical Education; and
      • Before- and after-school extracurricular physical activity opportunities such as physical activity clubs, intramural activities, and interscholastic sports.

3. *Policy strategies*
   - Create strategic partnerships among federal, state and local government, academic institutions and private organizations to promote healthy diets and physical activity.
   - Provide explicit support, reinforcement, and inducements to making healthy choices such as taking stairs rather than riding elevators or eating fruits or vegetables instead of less healthy foods.
   - Change cultural and organizational norms for physical activity and body weight.

4. *Worksite strategies*
   - Provide healthy snacks in vending machines, in break rooms, and at company events.
   - Disseminate nutrition information to employees.
   - Offer a health risk appraisal (HRA) to all employees and follow up with those at risk.
   - Form a support group to help employees who are trying to lose weight.

5. *Health plan strategies*
   - Work with health care plans to develop and evaluate prompts for counseling patients about nutrition, physical activity, and body weight regulation.
   - Help health care plans coordinate their preventive care activities with community efforts to promote physical activity and healthy nutrition.

3. TOBACCO USE

The Issue

Cigarette smoking is the single most preventable cause of disease and death in the U.S., with more than 430,000 deaths per year attributed to tobacco.

Across the country, smoking results in more deaths each year than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined. Smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung diseases. Research data show that in 1998, 24% of the country's adults and 35% of adolescents smoked cigarettes.

In Rhode Island

Rhode Island research statistics closely follow the national rates, with 23% of the state's adults and 35% of the state's adolescents reporting that they smoke. State objectives seek to lower those figures to 10% and 14%, respectively.

Greatest Health Disparities

The highest rates of smoking are among:

- Adults aged 18 to 44,
- Rhode Islanders living in urban areas of the state,
- Rhode Islanders with lower incomes and levels of education,
- White adolescents, and
- Adolescents in 12th grade.

Additionally, adult males have a higher smoking rate than adult females. Black adults have a higher smoking rate than White and Hispanic adults.

Rhode Islanders who are 75 years and older have already met the 2010 target.

Meeting the Tobacco Use Challenge

1. *Community based strategies*
   - Create sustained mass media education (campaigns), developed using formative research, and disseminated through television, radio, billboards, and print media.

TOBACCO USE IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

ADULTS OBJECTIVE: Reduce cigarette smoking by adults.

| 10% | 23%[1] |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

ADOLESCENTS OBJECTIVE: Reduce cigarette smoking by adolescents.

| 14% | 35%[2] |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
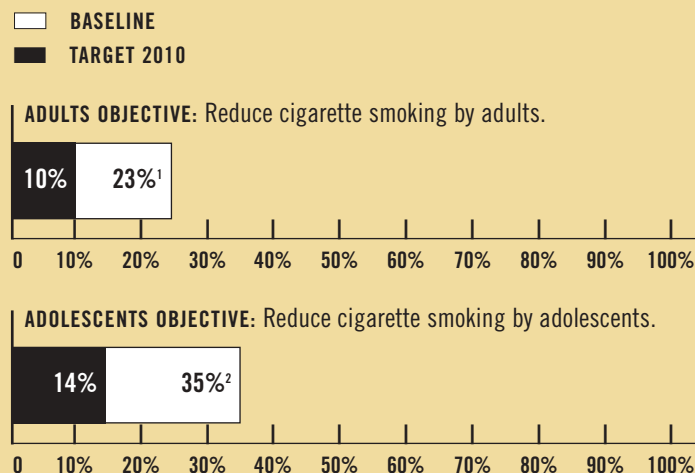
Data Sources: 1) 1998-2000 BRFSS; 2) 1997 YRBS

- Engage youth in developing and implementing tobacco control interventions.
- Promote governmental and voluntary policies to promote clean indoor air.
- Develop partnerships with local organizations.

2. *School based strategies*
   - Implement evidence-based curricula.
   - Provide teacher training.
   - Offer smoking cessation services.
   - Encourage parental involvement.
   - Link school-based efforts with local community coalitions and statewide media and educational campaigns.

3. *Policy strategies*
   - Implement smoking bans and restrictions to limit smoking in workplaces and other public areas.
   - Increase the unit price for tobacco products by raising the product excise tax.
   - Enforce current anti-tobacco laws by:
     - Conducting frequent retailer compliance checks (four per outlet per year, funds permitting) to identify retailers who sell tobacco to minors; and
     - Providing comprehensive merchant education, including information on health effects, to deter retailer violators.

4. *Worksite strategies*
   - Offer employees and their spouses smoking cessation classes to help them quit.

- Offer a health risk appraisal (HRA) to all employees, and follow up with tobacco users.
- Work with your health plan to ensure coverage for all tobacco use cessation services recommended by the U.S. Public Health Service.

5. *Health care system strategies*
   - Prompt health care providers to identify and to discuss with tobacco-using patients the importance of quitting ("provider reminder"), combined with an education program for providers, so that they can help their patients quit tobacco use ("provider education").
   - Implement patient telephone support (quit lines) combined with other interventions such as distribution of materials about quitting, formal individual or group counseling, or nicotine replacement therapies (including patches or gum).
   - Reduce patient out-of-pocket costs for effective treatments for tobacco use and dependence by providing the services within the healthcare system, or providing coverage for or reimbursement of patients for expenditures on (1) cessation groups or (2) nicotine replacement or other pharmacological therapies.

4. SUBSTANCE ABUSE

The Issue

Alcohol and illicit drug use are associated with many of this country's most serious public health concerns, including violence, injury, and HIV infection. Long-term heavy drinking can lead to heart disease, cancer, and alcohol-related liver disease.

Alcohol abuse is associated with motor vehicle crashes, homicides, suicides, and drowning – leading causes of death among youth. The annual economic costs to the U.S. from alcohol abuse were estimated to be $167 billion in 1995, and the costs from drug abuse were estimated to be $110 billion.

Alcohol and illicit drug use are associated with child and spousal abuse, sexually transmitted diseases, pregnancy, school failure, motor vehicle crashes, escalation of health care costs, low worker productivity, and homelessness.

National figures show that in 1998, 79% of adolescents had *not* used alcohol or illicit drugs in the previous 30-day period. In 1999, 6% of adults reported using illicit drugs in the previous 30-day period, and 17% of adults reported binge drinking in the previous 30-day period.

In Rhode Island

According to recent survey data, approximately 45% of the state's adolescent population has *not* used alcohol or illicit drugs in the past 30 days. Specifically, 48% of adolescents reported *no* alcohol use in the past 30 days, 96% reported *no* cocaine use during the same time period, and 71% reported *no* marijuana use in the past 30 days.

Seven percent (7%) of Rhode Island adults have used some form of illicit drug in the past 30 days, and 16% reported at least one incident of binge drinking during the same time period. State targets are charted in the accompanying tables.

SUBSTANCE ABUSE IN RHODE ISLAND

▢ BASELINE
◼ TARGET 2010

ADULTS (ILLICIT DRUGS) OBJECTIVE: Reduce the proportion of adults using any illicit drugs during the past 30 days.

6% 7%[1]

| 0 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
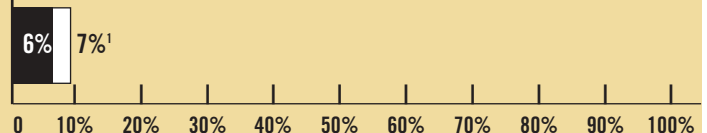
ADULTS (BINGE DRINKING) OBJECTIVE: Reduce binge drinking by adults in the past month.

6% 16%[2]

| 0 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
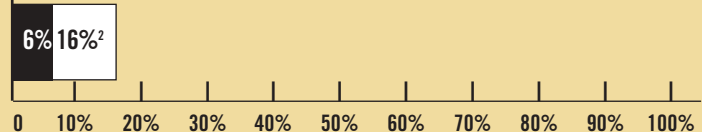
Data Sources: 1) 1999 NHSDA; 2) 1999 BRFSS

SUBSTANCE ABUSE IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

ADOLESCENTS OBJECTIVE: Increase the proportion of adolescents *not* using alcohol or any illicit drugs during the past 30 days.

45%[1]   75%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
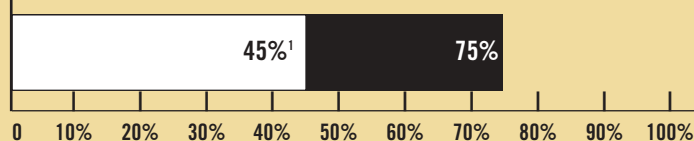
ADOLESCENTS (ALCOHOL): Increase the proportion of adolescents who report *no alcohol* use in the past 30 days.

48%[1]   75%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

ADOLESCENTS (COCAINE): Increase the proportion of adolescents who report *no cocaine* use in the past 30 days.

96%[1] 99%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
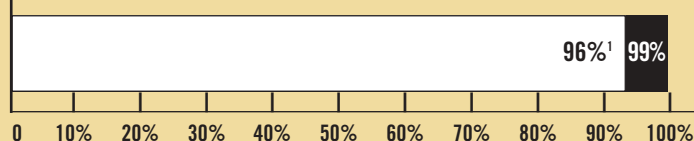
ADOLESCENTS (MARIJUANA): Increase the proportion of adolescents who report *no marijuana* use in the past 30 days.

71%[1]   85%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

Data sources: 1) 1997 YRBS

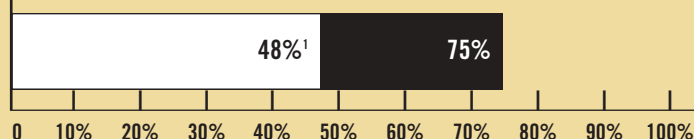### Greatest Health Disparities

The highest rate of alcohol and illicit drug use is among **adolescents in 12th grade**. The highest rate of marijuana abuse is among **White adolescents.**

Additionally, Black adults have higher rates of substance abuse than White and Hispanic adults; Rhode Islanders living in urban areas have higher rates of substance abuse than those in non-urban areas; and Rhode Islanders without disabilities have higher rates of substance abuse than those with disabilities.

Binge Drinking

The highest rates of binge drinking are among:

• Rhode Islanders aged 18 to 24,
• Adult males, and
• Rhode Islanders who have more than a high school education.

Additionally, Rhode Islanders with lower household incomes have higher binge drinking rates than those with household incomes of $75,000 or more.

Adults aged 65 and over and the Asian/Pacific Islander population have already met the 2010 target for binge drinking.

Meeting the Substance Abuse Challenge

1. *Individually based strategies*
   • Build social and personal skills.
   • Cite immediate consequences.
   • Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
   • Provide transportation to prevention and treatment programs.

2. *Family based strategies*
   • Develop parenting skills.
   • Emphasize family bonding.
   • Offer sessions where parents and youth learn and practice skills.

- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.

3. *School based strategies*
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.

4. *Community based strategies*
- Develop integrated, comprehensive prevention strategies rather than onetime community-based events.
- Provide structured time with adults through mentoring.
- Develop sustained community awareness and media efforts, disseminated through multiple channels when the target audience is likely to be viewing or listening.

5. *Worksite strategies*
- Communicate a clear company policy on substance abuse.
- Implement worksite policies that discourage alcohol misuse and offer confidential assistance with problems.
- Offer health plans that cover the cost of screening, counseling, and treatment for substance misuse.
- Establish an employee assistance program (EAP) and/or link EAP to health promotion initiatives.

6. *Policy strategies*
- Increase beverage servers' legal liability.
- Increase the price of alcohol and tobacco through excise taxes.
- Enforce impaired-driving laws.

Components of Successful Programs

Successful substance abuse programs:

- Address knowledge and skills related to alcohol, tobacco, and illicit drugs, and offer participants opportunities to apply and practice new skills;
- Create lasting changes within individual, family, and school domains in an effort to create "caring communities" that share accountability for change;
- Stress the importance of entering into the world of the client and integrating services into it. For example, programs serving racially and ethnically diverse groups discourage the use of a "one size fits all" approach; and
- View individuals and families in relation to their strengths and assets rather than focusing on deficits.

5. RESPONSIBLE SEXUAL BEHAVIOR

The Issue

Unintended pregnancies and sexually transmitted diseases (STDs), including infection with the human immuno-deficiency virus (HIV), can result from unprotected sexual behaviors. About one-half of all new HIV infections in the U.S. occur among people under age 25 years, and the majority are infected through sexual behavior.

Sexually transmitted diseases are common in the U.S., with an estimated 15 million new cases of STDs reported each year. Almost 4 million of the new cases of STDs each year occur in adolescents.

National data from 1999 show that 85% of adolescents abstain from sexual intercourse or use condoms if they are sexually active. Twenty-three percent (23%) of unmarried, sexually active adult females used condoms.

In Rhode Island

In Rhode Island, 86% of adolescents either have never had sexual intercourse, have abstained from sexual intercourse in the past 3 months, or used condoms at last sexual intercourse. State objectives seek to raise this figure to 95%. Thirty percent (30%) of unmarried sexually active females and 47% of unmarried sexually active males use condoms. State objectives seek to raise those figures to 50% and 75%, respectively.

RI ADOLESCENTS AND SEXUAL BEHAVIOR

1997[1] data show that:

57% never had sexual intercourse

12% had sexual intercourse but not during the past 3 months

16% had sexual intercourse in the past 3 months and used a condom

15% had sexual intercourse in the past 3 months but did not use a condom

Data Sources: 1) 1997 YRBS

RESPONSIBLE SEXUAL BEHAVIOR IN RHODE ISLAND

☐ **BASELINE**

■ **TARGET 2010**

ADOLESCENTS OBJECTIVE: Increase the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past 3 months, or used condoms at last sexual intercourse.

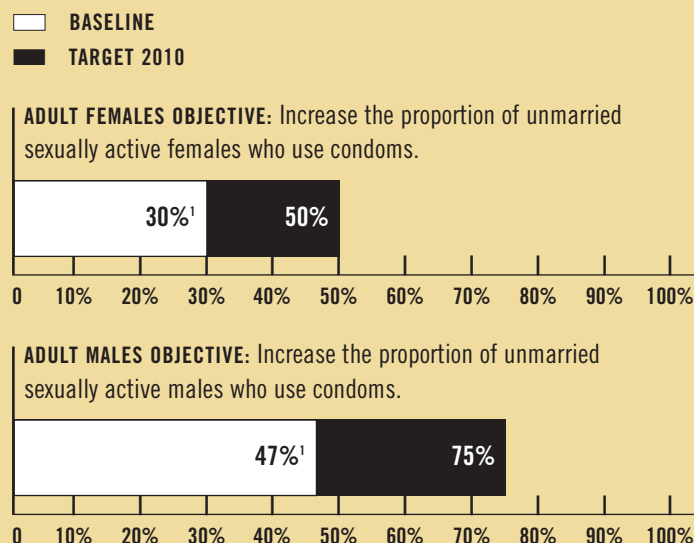| | | 86%[1] | 95% |

| 0 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

Data Sources: 1) 1997 YRBS

RESPONSIBLE SEXUAL BEHAVIOR IN RHODE ISLAND

☐ **BASELINE**
■ **TARGET 2010**

ADULT FEMALES OBJECTIVE: Increase the proportion of unmarried sexually active females who use condoms.

| 30%[1] | 50% |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

ADULT MALES OBJECTIVE: Increase the proportion of unmarried sexually active males who use condoms.

| 47%[1] | 75% |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
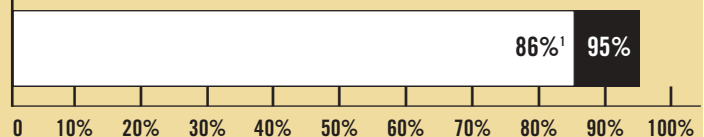
Data Sources: 1) 2002 BRFSS

Greatest Health Disparities

Although all adolescents need to increase their rates of abstinence and condom use to reach the 2010 target, greatest health disparities exist among **adolescents in 12th grade.**

Additionally, White youth have a lower rate of abstinence and condom use than Hispanic youth. Female youth have a lower rate of abstinence and condom use than male youth.

Adult Condom Use

While all sexually active, unmarried Rhode Island adults need to increase condom use to meet 2010 targets, condom use is lowest among unmarried, sexually active:

- Women aged 35 to 44,
- Men aged 35 to 49,
- Men with household incomes of $25,000 or less, and
- White males.

Meeting the Responsible Sexual Behavior Challenge

1. *Effective sexual education programs*
   - Provide sexuality education in a number of venues–homes, schools, churches, other community settings.
   - Include parents in sexuality education efforts so that they are consistent with parents' values and beliefs.

   - Provide adequate training in sexual health to all professionals who deal with sexual issues in their work, encourage them to use this training, and ensure that they are reflective of the populations they serve.
   - Ensure the availability of programs that promote both awareness and prevention of sexual abuse and coercion.

2. *Access to reproductive health services*
   - Eliminate disparities in sexual health status that arise from social and economic disadvantage and diminished access to information and health care services.
   - Improve access to sexual health and reproductive health care services for all persons in all communities.

3. *Community based strategies*
   - Increase public awareness and discussion of responsible sexual behavior.
   - Encourage opinion leaders to address issues related to sexual health and responsible sexual behavior in ways that are informed by the best available science and that respect diversity.
   - Involve people of both sexes and their families in community discussion.
   - Establish community-wide campaigns to discourage adolescent pregnancy and childbearing.
   - Develop initiatives that improve educational, employment, and leadership opportunities for young people.
   - Provide opportunities for meaningful community service for adolescents.

6. MENTAL HEALTH

The Issue

Approximately 20% of the U.S. population is affected by mental illness in a given year. Of all mental illnesses, depression is the most common disorder. More than 19 million adults in the U.S. suffer from depression. Major depression is the leading cause of disability, and it is the cause of more than two-thirds of suicides each year.

A person with a depressive disorder is often unable to fulfill the daily responsibilities of being a spouse, a partner, or a parent. The social misunderstanding of mental illness and the associated stigmatization prevent many people with depression from seeking professional help. The total estimated cost, direct and indirect, of mental illness in the U.S. in 1996 was $150 billion.

Healthy People 2010 data from 1997 show that 23% of adults with recognized depression received treatment. In 1998, the national suicide rate was 11/100,000.

MENTAL HEALTH IN RHODE ISLAND

☐ **BASELINE**
■ **TARGET 2010**

DEPRESSION: Increase the proportion of adults with recognized depression who receive treatment.

51%[1]	75%	

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
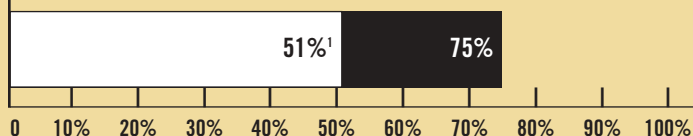
Data Sources: 1) 2002 Adjusted BRFSS

In Rhode Island

The state's suicide rate is 10/100,000 for all ages. State objectives seek to reduce that figure to 4/100,000.

In Rhode Island, 51% of adults with recognized depression receive treatment. State objectives seek to raise that percentage to 75%.

Greatest Health Disparities

The highest rates of suicide are among **adult males**.

Meeting the Mental Health Challenge

1. *Prevent suicide by:*
   • Promoting awareness that suicide is a public health problem that is preventable;
   • Promoting efforts to reduce access to lethal means and methods of self-harm; and
   • Improving reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

2. *Reduce the stigma surrounding mental illness by:*
   • Increasing public awareness and understanding of mental disorders;
   • Advancing and implementing a national campaign to reduce the stigma of seeking care, and a national strategy for suicide prevention; and
   • Continuing to conduct research on brain and behavior to generate ever more effective treatments.

3. *Reduce disparities in access to mental health services among different population groups by:*
   - Improving access to quality care that is culturally competent;
   - Improving access to quality care in rural and geographically remote areas;
   - Increasing the supply of providers in underserved areas;
   - Ensuring full parity for mental health services in both private and public health insurance coverage;
   - Increasing public investment in mental health services, especially under the Medicaid program, which provides coverage to populations with some of the highest rates of mental and emotional problems; and
   - Reducing financial barriers to treatment.

4. *Ensure that early mental health screening, assessment, and referrals to services are common practice by:*
   - Facilitating entry into treatment through multiple portals of entry: primary health care, schools, workplaces, and the child welfare system;
   - Promoting the mental health of young children;
   - Improving and expanding school mental health programs; and
   - Screening for co-occurring mental and substance use disorders and linking with integrated treatment strategies.

MENTAL HEALTH IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

SUICIDE: Reduce the suicide rate.

| 4 / 100,000 | 10 / 100,000[1] |

0 1 2 3 4 5 6 7 8 9 10

(INCIDENCE / 100,000 POPULATION)
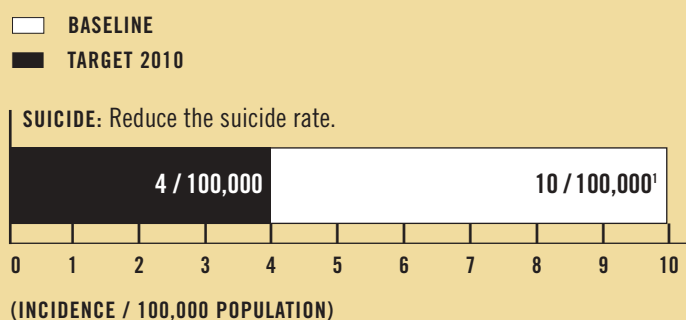
Data Sources: 1) 1999 Vital Records

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5. *Ensure the use of effective treatments and services by:*
   - Supporting basic and applied research;
   - Delivering state-of-the-art treatments that focus on recovery;
   - Promoting information dissemination;
   - Furthering inter-agency collaboration;
   - Enhancing opportunities for professional training;
   - Promoting workforce diversity;
   - Expanding interdisciplinary training; and
   - Improving coordination among service providers.

7. INJURY AND VIOLENCE

The Issue

More than four hundred Americans die each day from injuries due primarily to motor vehicle crashes, firearms, poisonings, suffocation, falls, fires, and drowning. In 1997, 32,436 individuals died from firearm injuries. Of this number, 42% were victims of homicide. In 1997, homicide was the third leading cause of death for children aged 5 to 14 years, indicating an increasing trend in childhood violent deaths. In 1996, more than 80% of infant homicides were considered to be fatal child abuse.

Nationally, death rates associated with motor vehicle-traffic injuries are highest among individuals aged 15 to 24 years.

Data from 1999 report 15 deaths per 100,000 people in the U.S. related to automobile crashes, and 6 homicides per 100,000 people.

In Rhode Island

The state reports 9 deaths per 100,000 people caused by motor vehicle crashes, and 3 homicides per 100,000 people. State objectives seek to reduce those figures to 7/100,000 and 2/100,000 respectively.

Greatest Health Disparities

Rhode Islanders with the highest rates of death by homicide and by motor vehicle crashes are:

• Male Rhode Islanders,
• Blacks of all ages, and
• Rhode Islanders aged 15 to 24 and 85+.

INJURY AND VIOLENCE IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

VEHICLE CRASHES: Reduce deaths caused by motor vehicle crashes.

7 / 100,000   9 / 100,000[1]

0 1 2 3 4 5 6 7 8 9 10

HOMICIDES: Reduce homicides.

2 / 100,000   3 / 100,000[1]

0 1 2 3 4 5 6 7 8 9 10

(INCIDENCE / 100,000 POPULATION)
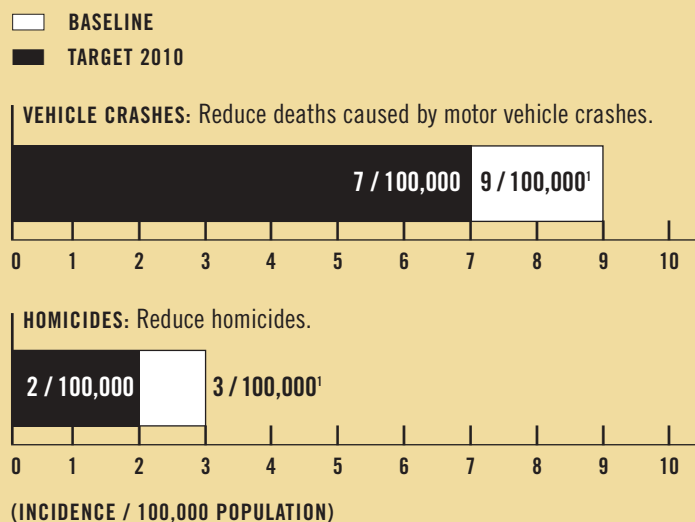
Data Sources: 1) 1996-1998 NVSS

The incidences of death by homicide and by motor vehicle crashes among Rhode Island females are low, and this population has met the 2010 target for reducing injury and violence.

Meeting the Injury and Violence Challenge

Motor vehicle accident prevention is a distinct category that has been carefully studied for decades. The issue of homicide prevention crosses a number of different issues such as intimate partner violence, youth violence, and criminal behavior. As a result, the recommended interventions depend on the context in which the homicide was committed.

MOTOR VEHICLE OCCUPANT INJURY

1. *Increase the proper use of child safety seats by*:
   • Providing free loaner child safety seats;
   • Rewarding parents for obtaining and correctly using child safety seats; and
   • Directly rewarding children for correctly using safety seats.

2. *Increase the use of safety belts by*:
- Implementing primary enforcement laws that allow police to stop motorists solely for being unbelted;
- Increasing citations and the number of officers on patrol; and
- Encouraging increased citations during an officer's normal patrol.

3. *Reduce alcohol impaired driving by enforcing*:
- 0.08% blood alcohol concentration (BAC) laws;
- Sobriety checkpoints; and
- Minimum legal drinking age laws.

VIOLENCE AND CRIME PREVENTION STRATEGIES

1. *Individually and family based strategies*
- Implement programs that improve family relations and provide training in parenting skills, including education about child development and the factors that predispose children to violent behavior, and exercises to help parents develop skills for communicating with their children and for resolving conflict in nonviolent ways.
- Equip children with the skills they need to deal effectively with difficult social situations, such as being teased or being the last one picked to join a team.
- Improve children's ability to avoid violent situations and solve problems nonviolently by enhancing their social relationships with peers, teaching them how to interpret behavioral cues, and improving their conflict-resolution skills.
- Provide family therapy by clinical staff for delinquent and pre-delinquent youth.

- Provide battered women's shelters for women who take other steps to change their lives.
- Provide Orders of Protection for battered women.

2. *School based strategies*
- Implement programs aimed at clarifying and communicating norms about behaviors by establishing school rules, improving the consistency of their enforcement or communicating norms through school-wide campaigns.
- Group youth into smaller "schools-within-schools" to create smaller units, more supportive interactions, or greater flexibility in instruction.

3. *Policy strategies*
- Provide short-term vocational training programs for older male ex-offenders no longer involved in the criminal justice system.
- Provide intensive, residential training programs for at-risk youth.
- Provide prison-based vocational education programs for adults.
- Implement law enforcement strategies that focus police resources on proven techniques to decrease crime, such as increased directed patrols in street-corner hot spots of crime and proactive arrests of serious repeat offenders.

8. ENVIRONMENTAL QUALITY

The Issue

An estimated 25% of preventable illnesses worldwide can be attributed to poor environmental quality.

Air Quality

In the U.S., air pollution alone is associated with an estimated 50,000 premature deaths and an estimated $40 billion to $50 billion in health-related costs annually. Three indicators of air quality are ozone (outdoor), radon levels (indoor), and environmental tobacco smoke (indoor).

In 1997, approximately 43% of the U.S. population lived in areas designated as nonattainment areas for established health-based standards for ozone. During the years 1988 to 1994, 88% of non-smokers were exposed to environmental tobacco smoke (ETS). An estimated 15 million children were exposed to secondhand smoke in their homes in 1996. ETS increases the risk of heart disease and respiratory infections in children and is responsible for an estimated 3,000 cancer deaths of adult non-smokers.

Air quality inside a building impacts both the comfort and health of its occupants. Long-term exposure to pollutants such as radon can lead to lung cancer. Data from the 1998 NHIS show that 17% of persons live in households that are tested for radon.

Lead Exposure

Although considerable progress has been made in reducing blood lead levels in the Nation's children, lead poisoning remains another preventable environmental health problem in the U.S. National data from the years 1999 - 2000 indicate that 2% of children had elevated blood lead levels (blood lead levels meeting or exceeding 10 micrograms per deciliter). CDC requires all state and local Childhood Lead Poisoning Prevention Programs to develop a strategic plan to eliminate childhood lead poisoning as a public health problem by year 2010.

Water Quality

Most people in the U.S. obtain their drinking water from public water supply systems. The EPA has established regulations to ensure that community water systems are safe. Compliance with the established regulations is one measure of the public's receipt of a safe water supply, free from disease-causing agents. Data from 1995 show that 85% of people in the U.S. receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

Food Quality

Foodborne illnesses impose another burden on public health and contribute significantly to the cost of health care. From 1988 through 1992, foodborne disease outbreaks caused an annual average of more than 15,000 cases of illness in the U.S. CDC data show that in 1997, 25 per 100,000 Americans were infected by Campylobacter species and 14/100,000 were infected by Salmonella species, two key foodborne pathogens.

ENVIRONMENTAL QUALITY IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

OZONE: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.
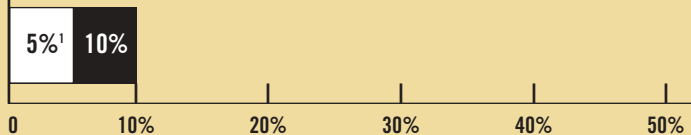
0% ▮ ▯ 100%[1]

| 0 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
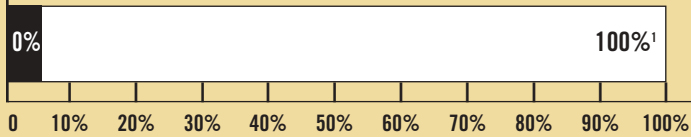
Data Sources: 1) 1998 RI DEM/OAR

ENVIRONMENTAL QUALITY IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

RADON: Increase the proportion of persons who live in homes tested for Radon concentrations.*

5%[1] ▯ 10% ▮

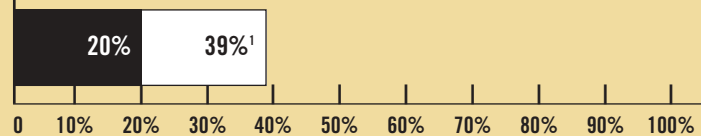| 0 | 10% | 20% | 30% | 40% | 50% |

Data Sources: 1) 1994-2000 RI Radon Test Database

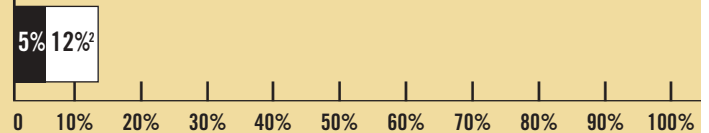* Does not include testing by non-certified individuals

ENVIRONMENTAL QUALITY IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

ETS: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.*

20% ▮ 39%[1] ▯

| 0 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

LEAD: Eliminate elevated blood lead levels in children.

5% ▮ 12%[2] ▯

| 0 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

Data Sources: 1) 2001 RI HIS; 2) 2000 RICLPPP

* Proxy Objective: Reduce the proportion of households where smoking is permitted inside the house or inside the car all or most of the time. Data includes households reporting regular smoking in the house or apartment, regular smoking in the vehicle (for households with children under 18), and those that have no rules prohibiting smoking in the house or car.

In Rhode Island

In 2000, Rhode Island exceeded the U.S. Environmental Protection Agency's standard for ozone concentration a total of 11 times. Any exceedance leads to 100% exposure of the Rhode Island population. The target for 2010 is to have no exceedances.

Thirty-nine percent (39%) of non-smokers report household exposure to tobacco smoke. State objectives seek to reduce that figure to 20%.

Five percent (5%) of Rhode Islanders live in households that are tested for radon. State objectives seek to raise that figure to 10% by 2010.

Twelve percent (12%) of Rhode Island children had first time cases of elevated blood lead levels in 2000. State objectives seek to reduce that figure to 5% by 2010. Based on the analysis of housing quality and incidence of elevated blood lead levels, the Department of Health defines the elimination of childhood lead poisoning by 2010 as follows:

"To decrease the proportion of new cases of lead poisoning in children less than six years of age (defined as a blood lead level of 10 mcg/dL or more) to less than 5% in all Rhode Island communities, without significantly decreasing availability of lead safe/lead mitigated housing."

Rhode Island data from 2002 show that 81% of people in the state who are served by community water systems receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act. State objectives seek to increase that number to 95%.

In 2002, 16/100,000 Rhode Islanders were infected by Campylobacter species and 19/100,000 were infected by Salmonella species, two key foodborne pathogens. State objectives seek to reduce those numbers to 12/100,000 and 7/100,000 respectively.

Greatest Health Disparities

Black children have the highest rate of elevated blood lead levels. White children have the lowest rate of elevated blood lead levels.

Because exposure to ozone concentration is not measured on a statewide basis, potential disparities between racial and ethnic groups are not known.

ENVIRONMENTAL QUALITY IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

WATER: Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

81%[1]   95%

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
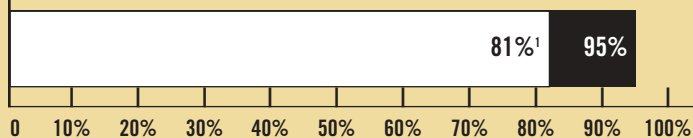
Data Sources: 1) 2002 ODWQ

Disparity data on the remaining environmental quality objectives are forthcoming.

Meeting the Environmental Quality Challenge

1. *Reduce sources of and exposure to emissions by:*
   - Encouraging cleaner electric generation at utilities;
   - Displacing a percentage of power generation with a combination of biomass, solar, hydro and wind power generation;
   - Reducing residential energy demand through improvements in water heater designs and reduced hot water consumption;
   - Encouraging use of mass transit, carpools, telecommuting, and the use of alternative lower carbon fuel and advanced technology vehicles;
   - Reducing industrial process emissions; and
   - Educating the public about ways to reduce their exposure to emissions.

2. *Increase radon testing by:*
   - Promoting increased testing and mitigation of existing housing by the public through public outreach and education and during residential real estate transactions.

3. *Reduce exposure to environmental tobacco smoke by:*
   - Educating the public, employers, and employees about the health effects of environmental tobacco smoke and the need for restrictions;
   - Establishing and publicizing telephone hotlines for reporting violations of clean indoor air ordinances and laws and investigating reports received; and
   - Enforcing public and private policies that reduce or eliminate exposure to environmental tobacco smoke.

ENVIRONMENTAL QUALITY IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

CAMPYLOBACTER: Reduce infections caused by key foodborne pathogens: Campylobacter species.

12/100,000   16/100,000[1]

0 2 4 6 8 10 12 14 16 18 20
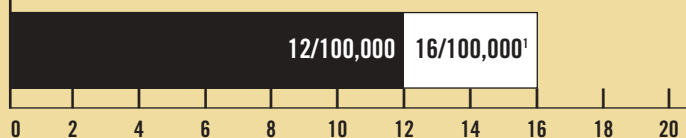
SALMONELLA: Reduce infections caused by key foodborne pathogens: Salmonella species.

7/100,000   19/100,000[1]

0 2 4 6 8 10 12 14 16 18 20
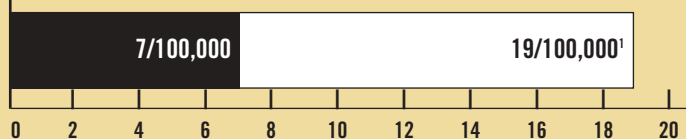
Data Sources: 1) 2002 RI DOH Division of Disease Prevention and Control

4. *Reduce lead exposure by:*
   - Passing legislation to reduce the entry of lead into the environment and into consumer products with which children may come in contact;
   - Using code enforcement and other legal avenues to require abatement of lead in housing units;
   - Educating parents of infants and toddlers and expectant parents about how they can help reduce the risk of lead exposure in their homes;
   - Collaborating with agencies working on environmental health and housing issues;
   - Providing financial incentives to promote environmental abatement; and
   - Improving screening and follow up by health care providers and health insurance systems.

5. *Improve water safety by:*
   - Delineating protection areas for all public drinking water sources;
   - Creating an inventory of existing and potential sources of contamination;
   - Communicating the results of the inventory to the general public; and
   - Preparing and implementing a source protection plan.

6. *Improve food safety by:*
   - Improving the management and effectiveness of regulatory programs;
   - Improving the coordination of food safety activities with other public health agencies; and
   - Protecting meat, poultry, and egg products against intentional contamination.

9. IMMUNIZATION

The Issue

Immunizations are among the greatest public health achievements of the 20th century. Immunizations can prevent disability and death from infectious diseases, and can help control the spread of infection.

Immunization coverage levels among adults are not as high as the levels among children. The health benefits of vaccination for adults, however, are just as great as those for children. Immunizations against influenza and pneumococcal disease can prevent serious illness and death. Pneumonia and influenza deaths together constitute the sixth leading cause of death in the U.S. Influenza causes an average of 110,000 hospitalizations and 20,000 deaths annually; pneumococcal disease causes 10,000 to 14,000 deaths annually.

Nationally, data from 1998 show that 73% of young children receive all recommended* immunizations on time. In the adult population, 64% of adults aged 65 years and older are vaccinated annually against influenza. In the same age group, 46% have ever been vaccinated against pneumococcal disease.

In Rhode Island

In Rhode Island, 81% of children currently receive all recommended* immunizations on time. With regard to adults aged 65 and older, 74% are vaccinated annually against influenza, and 58% report ever having been vaccinated against pneumococcal disease. State objectives seek to raise those figures to 100%, 95%, and 75%, respectively.

Greatest Health Disparities

Influenza
Although increases in the number of all seniors in Rhode Island immunized against influenza must occur in order to meet the 2010 target, greatest health disparities exist among:

• Seniors aged 65 to 74,
• Seniors with less than a high school education, and
• Seniors who live in urban areas.

Pneumococcal Disease
Although increases in the number of all seniors in Rhode Island immunized against pneumococcal disease must occur in order to meet the 2010 target, greatest health disparities exist among:

• Seniors aged 65 to 74, and
• Seniors who do not have a disability.

*Recommended vaccines are: all vaccines that are universally recommended for at least five years.

IMMUNIZATION IN RHODE ISLAND

☐ **BASELINE**
■ **TARGET 2010**

CHILDREN: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for the last 5 years.

81%[1]   100%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
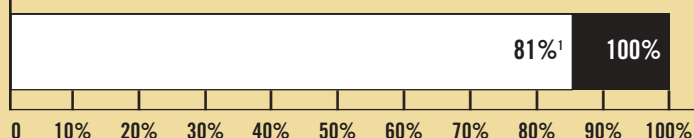
Data Sources: 1) 2000 NIS

IMMUNIZATION IN RHODE ISLAND

☐ **BASELINE**
■ **TARGET 2010**

INFLUENZA: Increase the proportion of adults aged 65 years and older who are vaccinated annually against influenza.

74%[1]   95%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
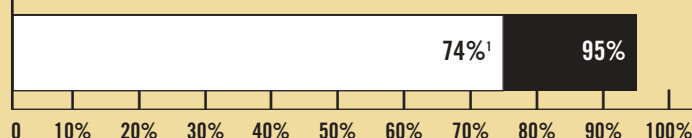
PNEUMOCOCCAL: Increase the proportion of adults aged 65 and older who have been vaccinated against pneumococcal disease.

58%[1]   75%

0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
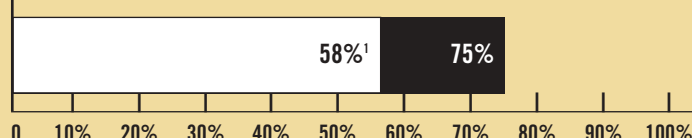
Data Sources: 1) 1998-2000 BRFSS

Meeting the Immunization Challenge

1. *Improve the ability of providers and health care systems to record, track, and promote appropriate immunizations by*:
   • Implementing immunization registries;
   • Reminding members of the target population when their immunizations are due or are late through telephone calls, letters, or postcards (client reminder/recall systems); and
   • Reminding providers when individual clients are due or overdue for specific immunizations, through client flagging charts, reminders by computer or by mail (provider reminder/recall).

2. *Educate the public about the importance of immunizations by*:
   • Implementing public awareness and education supplemented with expanded hours or access and reduced out-of-pocket costs for clients.

3. *Improve access to immunization for people at risk for not being immunized by*:
   • Expanding access to immunizations by decreasing the distance between immunization settings and population, and increasing hours of operation;
   • Reducing out-of-pocket costs for clients by providing free immunizations, reducing administrative costs, providing insurance coverage, and reducing co-payments for immunizations at point of service; and
   • Identifying at-risk, low-income children in non-medical settings such as WIC program offices.

10. ACCESS TO HEALTH CARE

The Issue

A primary indicator of access to health care is having health insurance. More than 44 million people in the U.S. do not have health insurance, including 11 million children. People with health insurance are more likely to have a primary care provider and to have received appropriate preventive care such as a recent Pap test, immunization, or early prenatal care. Adults with health insurance are twice as likely to receive a routine checkup in comparison to adults without health insurance.

More than 40 million Americans do not have a particular doctor's office, clinic, health center, or other place where they usually go to seek health care or health-related advice. Even among privately insured people, a significant number lack an ongoing source of care, or they report difficulty in accessing needed care due to financial constraints or insurance problems.

Recent research shows that 83% of the country's population has health insurance, and 87% has a specific source of ongoing health care. Nationally, 74% of pregnant women receive early and adequate prenatal care.

In Rhode Island

Currently 91% of Rhode Island adults have some form of health insurance. Approximately 84% of adults reported having a specific source of ongoing care. Ninety-one percent (91%) of the state's pregnant women receive early and adequate prenatal care. State objectives seek to raise those figures to 100%, 96%, and 100% respectively.

Greatest Health Disparities

Insurance Coverage

Although no group has reached 100% insurance coverage, the following groups are farthest from reaching the goal:

• Black adults,
• Rhode Islanders with household incomes of less than $25,000,
• Adults aged 18 to 24, and
• Rhode Islanders with less than a high school degree.

Additionally, males have lower rates of insurance coverage than females, and those living in non-urban areas have lower rates of insurance coverage than urban dwellers.

Ongoing Source of Care

The following groups are the farthest from reaching the goal of having an ongoing source of health care:

• Adults aged 18 to 24,
• Male adults, and
• Rhode Islanders with incomes of $25,000-$34,999.

Additionally, fewer Rhode Islanders with lower levels of education have a specific source of ongoing health care than those with higher education levels.

Adults between the ages of 65 and 74 have nearly met the 2010 target for having a source of ongoing health care.

ACCESS TO HEALTH CARE IN RHODE ISLAND

☐ BASELINE
■ TARGET 2010

INSURANCE: Increase the proportion of persons* with health insurance.

| | 91%[1] | 100% |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

ONGOING CARE: Increase the proportion of persons who have a specific source of ongoing care.

| | 84%[2] | 96% |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PRENATAL CARE: Increase the proportion of pregnant women who receive early and adequate prenatal care.

| | 91%[3] | 100% |

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Data Sources: 1) 1998-2000 BRFSS; 2) 2000 BRFSS; 3) 1997-1999 Vital Records

*Data are for adults aged 18-64.

Prenatal Care

With regards to accessing adequate prenatal care, greatest disparities exist among:

• Hispanic pregnant women,
• Black pregnant women,
• Asian/Pacific Islander pregnant women, and
• American Indian/Alaska Native pregnant women.

Meeting the Access to Health Care Challenge

1. *Improve coverage of the uninsured by:*
   • Modifying benefit packages and/or increasing cost-sharing for certain populations to allow for coverage of new populations;
   • Expanding coverage through public-private linkages, such as subsidizing employer-sponsored insurance premiums through Medicaid or CHIP to tap federal matching funds and retain employer/employee contributions;
   • Simplifying program administration and improving outreach efforts;
   • Expanding eligibility in public programs; and
   • Increasing the number of providers available in underserved areas.

2. *Build on private coverage by:*
   • Developing policies to encourage more people to use employer-based insurance;
   • Providing consumer and employer education about existing options within the private insurance market (e.g., tax credit programs, purchasing pools, and recent regulatory reforms);
   • Targeting the working uninsured and small employers, where the majority of the uninsured are employed; and
   • Collaborating with health plans in developing and modifying an incentives program to enhance health plan "buy in" and cooperation.

3. *Increase access to and usage of prenatal care by:*
   • Streamlining the application process;
   • Increasing income eligibility to 200% of poverty;
   • Offering free pregnancy testing;
   • Offering toll free hotlines;
   • Conducting outreach campaigns; and
   • Increasing reimbursement to providers.

A HEALTHIER RHODE ISLAND BY 2010: YOUR CHALLENGE

Overview of the Conference, Plan Feedback and Exemplary Rhode Island Programs

Conference Overview

Throughout the Healthy Rhode Islanders 2010 project, HEALTH has been committed to collaborating with community organizations across the state to maximize this Plan's success. To strengthen community partnerships, HEALTH hosted a landmark conference entitled "A Healthier Rhode Island by 2010: Your Challenge" on October 30, 2003. HEALTH invited over 600 individuals from local and state agencies across Rhode Island to attend. Each invitee received a draft of the Healthy Rhode Islanders 2010 Plan for review.

At the conference, HEALTH presented the Plan for Action, then invited and discussed input on the Plan from among the conference's 100 attendees. Conference participants were also invited to comment on the Plan using a form provided at the conference.

Following this discussion, eight panelists from Rhode Island organizations presented their sector's best practices across the ten HRI 2010 leading health indicators. Panelists addressed how HRI 2010 objectives could be achieved in venues including medical settings (i.e., health centers, hospitals), community organizations, worksite programs, the state legislature and the media.

Feedback on the Plan

Generally, conference participants and others who commented on the Plan liked its format and presentation.

They had several suggestions regarding the content of the Plan. For example:

1. *Some thought that more recent data should be used where available.* However, the data presented in this Plan serve as baselines. More recent data will be used to chart progress over the decade.

2. *Some requested elaborating on or adding to the best practices presented in the Plan. Attendees were particularly interested in best practices that address adolescent issues involving physical activity and substance abuse, and the problem of Rhode Island's uninsured.* For more in-depth information on best practices in your field(s) of interest, visit HEALTH's full report on evidence-based strategies and best practices available at www.health.ri.gov/chic/healthypeople/home.htm.

CONFERENCE PANELISTS

- Kerrie Jones Clark, Executive Director, RI Health Center Association

- Dennis Langley, Executive Director, Urban League of RI

- Barbara Morse, Health Reporter, WJAR NBC-10

- Patricia Martinez, Director of Community Relations, Governor's Office

- Michael Samuelson, Executive Lead for Health & Wellness, Blue Cross Blue Shield of RI

- Kathleen Hittner, MD, President & CEO, The Miriam Hospital

- Jeffrey Johnson, Chair, Worksite Wellness Council of Rhode Island, Chair, Board of Central RI Chamber of Commerce, Vice President of Community Relations, Beacon Mutual Insurance Company

RHODE ISLAND IN 2010: OUR VISION

INCREASE QUALITY & YEARS OF HEALTHY LIFE

www.health.ri.gov

RHODE ISLAND IN 2010: OUR VISION

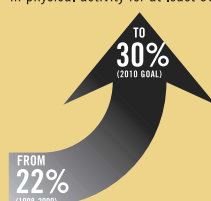## ELIMINATE HEALTH DISPARITIES

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

PHYSICAL ACTIVITY

THE CHALLENGE
Increase the percentage of adults who engage in physical activity for at least 30 minutes a day.

TO **30%** (2010 GOAL)

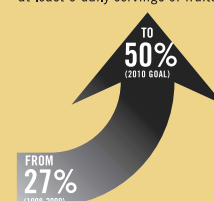FROM **22%** (1998-2000)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

OVERWEIGHT & OBESITY

THE CHALLENGE
Increase the percentage of people who eat at least 5 daily servings of fruits and vegetables.

TO **50%** (2010 GOAL)

FROM **27%** (1998-2000)

www.health.ri.gov

Educational banners were produced for each leading health indicator and for the Healthy People 2010 overarching goals. The banners were displayed at the conference and will be rotated throughout community organizations over the next six years. Photos of the banners are above and continue through page 39 of this Plan. To request that a banner be displayed in your organization, call 401-222-5117. To download color images of the banners, visit www.health.ri.gov/chic/healthypeople/home.htm.

3. *Some suggested further developing or adding the following issues to the Plan objectives: issues specific to the elderly, the availability of housing, and oral health.* These issues are critical to public health and are a priority for the State. The issues of housing and the elderly are represented in the following ways in this Plan:

- **Elderly adults** are incorporated in the data for a majority of objectives relating to adults, including physical activity, obesity, tobacco use, substance abuse, and access to health care. Under these indicators, disparities and strategies for intervention apply to elderly populations as well. Additionally, under the immunization leading health indicator, two objectives related to increasing vaccination for influenza and pneumococcal disease address the elderly specifically.

- The issue of **housing** is addressed under the Environmental Quality leading health indicator, in particular under the indoor air quality and lead exposure objectives.

For the purposes of this project we adopted Healthy People 2010's ten leading health indicators and 27 objectives associated with them. On the national level, Healthy People 2010 tracks over 450 objectives. There are numerous objectives related to oral health, availability of housing, and older adults. For more information on your issue of interest, including national data sources and disparities, please visit www.healthypeople.gov.

Healthy People 2010 does not specifically address the issue of housing availability, but rather focuses on the health-related risks of existing housing. For information on what Rhode Island is doing to address the issue of housing availability, visit Rhode Island Housing Resources Commission's website at www.hrc.ri.gov or call them at 401-450-1350.

A HEALTHIER RHODE ISLAND BY 2010

TOBACCO USE
TOBACCO HOTLINE: 1-800-TRY-TO-STOP

THE CHALLENGE
Reduce the number of youth who smoke.

FROM **35%** (1997)

TO **14%** (2010 GOAL)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

SUBSTANCE ABUSE

THE CHALLENGE
Reduce binge drinking by adults.

FROM **16%** (1999)

TO **6%** (2010 GOAL)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

RESPONSIBLE SEXUAL BEHAVIOR

THE CHALLENGE
Increase the percentage of adolescents who abstain from sex or use condoms if sexually active.

TO **95%** (2010 GOAL)

FROM **86%** (1997)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

MENTAL HEALTH

THE CHALLENGE
Increase the number of adults with recognized depression who receive treatment.

TO **75%** (2010 GOAL)

FROM **51%** (2002)

www.health.ri.gov

Exemplary RI Programs

Conference attendees were invited to submit examples of Rhode Island initiatives and programs that they feel are comparable to national best practices across the ten leading health indicators. Below is a sampling of the types of programs that people submitted:

The Samaritans, Inc
This non-profit agency is dedicated to **suicide prevention**. It operates a volunteer trained, confidential crisis/listening line that provides non-judgmental "befriending" and support to those who are depressed. In addition, the organization offers referrals to Rhode Island 911 during life-threatening emergencies and to hospitals and community mental health centers in other cases.

Visiting Nurse Services of Newport and Bristol Counties
This program provides mobile **immunization** clinics in places frequented by seniors such as senior housing, senior centers, churches, doctors' offices, and this agency's own offices. Clinics are conducted at all times of the day.

Rhode Island Department of Human Services
This agency provides Medicaid coverage for **smoking cessation** products and **lead** screening, treatment and follow-up, education, and abatement activities. In addition, the Rite Share premium assistance program helps low income working families maintain or enroll in employer-sponsored **health care coverage**, rather than using a waiting period to discourage movement from private to public coverage.

Mental Health Association of Rhode Island
This agency works to educate Rhode Islanders on **mental health** to: reduce stigma surrounding mental illness; improve access to culturally competent, quality care; provide early mental health screening, assessments, and referrals; and ensure use of effective treatments.

Rhode Island Victims' Advocacy and Support Center (RIVASC)
This agency provides several programs related to **injury and violence** including a community crisis response, a post-incarceration release re-entry initiative, and education and support for victims of crime statewide.

A HEALTHIER RHODE ISLAND BY 2010

INJURY & VIOLENCE

THE CHALLENGE
Reduce homicides.

FROM
3/100,000
(1996–98)

TO
2/100,000
(2010 GOAL)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

ENVIRONMENTAL QUALITY

THE CHALLENGE
Reduce the number of children with elevated blood lead levels.

FROM
12%
(2000)

TO
5%
(2010 GOAL)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

IMMUNIZATION
PREVENT HOSPITALIZATION THROUGH VACCINATION

THE CHALLENGE
Increase the percentage of adults aged 65 and over who get a flu vaccine every year.

TO
95%
(2010 GOAL)

FROM
74%
(1998–2000)

www.health.ri.gov

A HEALTHIER RHODE ISLAND BY 2010

ACCESS TO HEALTH CARE

THE CHALLENGE
Increase the percentage of persons who have a **specific source of ongoing care.**

TO
96%
(2010 GOAL)

FROM
84%
(2000)

www.health.ri.gov

City of Newport Parks Recreation and Tourism

This agency provides recreational **physical activity** programs for youth and teens using city parks, including a "no-cut" middle school basketball activity that accepts all youth "cut" from official school teams.

Kent YMCA

This organization provides a variety of programs to promote **physical activity** and prevent **overweight and obesity.** Programs include aerobics and strength training for members, including a beginners program for first-timers or those recently returning to an exercise regimen; CHAMPS— a cardiovascular and strength training program for people recently released from rehab; and programs partnering with local hospitals, such as Starting Over—a work-out program for breast cancer survivors.

Chariho Tri-Town Task Force for Substance Abuse Prevention

The mission of this task force is to bring **substance abuse prevention** to the Chariho community at large. The task force includes individuals from local groups such as police departments and schools. Current programs include: identifying peer leaders in middle and high schools to lead substance abuse prevention efforts; involving teens in performing classroom skits and presentations that encourage

tobacco prevention; and training 7th graders to teach 3rd graders about positively dealing with their own feelings and being sensitive to the feelings of others.

Next Steps

Moving forward, HEALTH will facilitate the dissemination of best practices throughout the State and assist local stakeholders in using this information to improve existing programs, policies and partnerships to help Rhode Island meet its 2010 targets.

While the focus of the HRI 2010 process will shift to the implementation of programs, policies and activities using this Plan as a guide, this Plan for Action is not the end of the State's planning. As additional priorities are identified, the planning process will continue to move forward.

APPENDIX A:

DATA SOURCES FOR HEALTHY RHODE ISLANDERS 2010 BASELINES AND DISPARITIES

BRFSS – Behavioral Risk Factor Surveillance System, Office of Health Statistics, Rhode Island Department of Health and National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC).

RI CLPPP – Childhood Lead Poisoning Prevention Program, Rhode Island Department of Health.

DDPC – Rhode Island Department of Health, Division of Disease Prevention and Control.

MCHD/DFH – Maternal Child Health Data, Division of Family Health, Rhode Island Department of Health.

NCHS – National Center for Health Statistics.

NHSDA – National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration (SAMHSA).

NIP – National Immunization Program.

NIS – National Immunization Survey, Office of Children's Preventive Health Services, Division of Family Health, Rhode Island Department of Health.

NVSS – National Vital Statistics System.

ODWQ – Office of Drinking Water Quality, Public Water System Supervision Compliance Data System.

RI DEM/OAR – Office of Applied Research, Rhode Island Department of Environmental Management.

RI HIS – Rhode Island Health Interview Survey, Office of Health Statistics, Rhode Island Department of Health.

RI Radon Test Database.

Vital Records – Vital Records, Office of Health Statistics, Rhode Island Department of Health.

YRBS – Youth Risk Behavior Survey, Office of Health Statistics, Rhode Island Department of Health and National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

APPENDIX B:

HEALTH DISPARITIES AT-A-GLANCE

The table below illustrates the groups with the greatest health disparities for each of the health indicators reviewed in this Plan. Disparities are presented starting with the group with the greatest disparity (i.e., farthest from the target for that objective). Until confidence intervals are available, greatest health disparities cannot be determined with statistical significance. Therefore this table represents face value disparities within each LHI. In addition, this table presents greatest health disparities among groups for which we currently have data.

Overall, there are 5 groups that most frequently appear to have significant disparities across several indicators. Taken as a whole, the data suggest that the following groups would benefit most from targeted interventions:

- Adult males,
- Rhode Islanders with lower levels of education (high school education or less),
- Rhode Islanders with lower levels of income (less than $35,000),
- Blacks of all ages, and
- Adolescents in the 12th grade.

Although the groups listed below have the *greatest* health disparities, improvements among all Rhode Islanders are necessary to reach most of the 2010 targets.

RHODE ISLANDERS WITH THE GREATEST HEALTH DISPARITIES WITHIN EACH LEADING HEALTH INDICATOR

PHYSICAL ACTIVITY	*Baselines*
Adults (State Baseline = 22%; Target = 30%)	
Lower levels of education (less than high school; high school grad/GED)	12%; 19%
Over age 25 (25-44; 45-64; 65-74; 75+)	21%; 23%; 22%; 14%
With disabilities	15%
Hispanic adults	16%
Black adults	17%
Lower levels of income (less than $25,000; $25,000-34,999; don't know/refused)	19%; 21%; 19%

PHYSICAL ACTIVITY

	Baselines
Adolescents (State Baseline = 62%; Target = 85%)	
Adolescent females	52%
Adolescents in 12th grade	55%
Hispanic adolescents	56%

OVERWEIGHT AND OBESITY

Adults (State Baseline = 17%; Target = 14%)	
Black adults	30%
Less than a high school education	28%
With disabilities	26%
Ages 45-64	21%
Adolescents (State Baseline = 25%; Target = 10%)	
Black adolescents	40%
Children and adolescents with household incomes below the federal poverty level	33%
Hispanic adolescents	31%
Fruits and Vegetables (State Baseline = 27%; Target = 50%)	
Black adults	18%
With less than a high school education	20%
Adult males	22%

TOBACCO USE

Adults (State Baseline = 23%; Target = 10%)	
Ages 18-44 (18-24; 25-44)	31%; 27%
Lower incomes (less than $25,000; $25,000-34,999; $35,000-49,999)	29%; 26%; 25%
Lower levels of education (less than high school; high school grad/GED; at least some college)	27%; 27%; 24%
Living in urban areas	26%
Adolescents (State Baseline = 35%; Target = 14%)	
Adolescents in 12th grade	49%
White adolescents	40%

SUBSTANCE ABUSE

	Baselines
Adolescents: Alcohol or Illicit Drugs (State Baseline = 45%; Target = 75%)	
Adolescents in 12th grade	30%
Adolescents: Marijuana (State Baseline = 71%; Target = 85%)	
White adolescents	68%
Binge Drinking (State Baseline = 16%; Target = 6%)	
Ages 18-24	31%
Adult males	24%
More than a high school education (high school grad/GED; at least some college; college grad or more)	15%; 14%; 14%

RESPONSIBLE SEXUAL BEHAVIOR

Adolescents (State Baseline = 86%; Target = 95%)	
Adolescents in 12th grade	69%
Unmarried Sexually Active Males (State Baseline = 47%; Target = 75%)	
Unmarried, sexually active males ages 35-49	38%
Unmarried, sexually active males with incomes less than $25,000	41%
White unmarried, sexually active males	43%
Unmarried Sexually Active Females (State Baseline = 30%; Target = 50%)	
Unmarried, sexually active females ages 35-44	18%

MENTAL HEALTH

Suicide (State Baseline = 10/100,000; Target = 4/100,000)	
Males	16/100,000

INJURY AND VIOLENCE

Homicide (State Baseline = 3/100,000 population; Target = 2/100,000)	
Blacks of all ages	16/100,000
Males	4/100,000
Motor Vehicle Crashes (State Baseline = 9/100,000 population; Target = 7/100,000)	
Blacks of all ages	15/100,000
Males	13/100,000
Rhode Islanders aged 15 to 24 and 85+	16/100,000

ENVIRONMENTAL QUALITY

Baselines

Lead Poisoning (State Baseline = 12%; Target = 5%)

Black children	23%

IMMUNIZATION

Flu Vaccine (State Baseline = 74%; target = 95%)

Living in urban areas	68%
Less than high school degree	69%
Ages 65-74	71%

Pneumococcal Vaccine (State Baseline = 58%; Target = 75%)

Ages 65-74	54%
Without disabilities	55%

ACCESS TO HEALTH CARE

Health Insurance Coverage (State Baseline = 91%; Target = 100%)

Incomes of less than $25,000	79%
Ages 18-24	83%
Black adults	83%
Less than a high school degree	86%

On-going Source of Care (State Baseline = 84%; Target = 96%)

Ages 18-24	73%
Adult males	79%
Incomes of $25,000 to $34,999	81%

Adequate Prenatal Care (State Baseline = 91%; Target = 100%)

Black women	84%
Asian/Pacific Islander women	85%
American Indian/Alaskan Native women	85%
Hispanic women	86%

APPENDIX C:

REFERENCES FOR HEALTHY RHODE ISLANDERS 2010 EVIDENCE-BASED STRATEGIES & BEST PRACTICES

Physical Activity

Non-Federal Task Force on Community Preventive Services. *The Guide to Community Preventive Services.* http://www.thecommunityguide.org/pa/default.htm (accessed October 23, 2003).

Partnership for Prevention. *HEALTHY WORKFORCE 2010: An Essential Health Promotion Sourcebook for Employers, Large and Small*, Fall 2001. http://www.prevent.org/publications/Healthy_Workforce_2010.pdf (accessed October 23, 2003).

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Bonnie, Richard J. and Mary Ellen O'Connell, Editors. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Board on Children, Youth, and Families, National Research Council, *Reducing Underage Drinking, A Collective Responsibility,* 2003. http://www.nap.edu/books/0309089352/html/ (accessed October 23, 2003).

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Responsible Sexual Behavior

Moncloa, Fe et. al. "Best Practices: The Teen Pregnancy Prevention Practitioner Handbook," *Journal of Extension,* April 2003, 41(2). http://www.joe.org/joe/2003april/tt1.shtml (accessed October 23, 2003).

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